

**Commonwealth of Massachusetts
Mandated Benefits Review**

**Review and Evaluation of Legislation Related to
Eating Disorders
House Bill No. 3024**

**Provided for:
The Joint Committee on Financial Services**

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EXECUTIVE SUMMARY

This report was prepared by the Division of Health Care Finance and Policy (Division) pursuant to the provisions of M.G.L. c. 3, § 38C, which requires the Division to evaluate the impact of mandated benefit bills referred by legislative committee for review, and to report to the referring committee. The Joint Committee on Financial Services referred proposed House Bill 3024, named, "*An Act for Certain Health Care Insurance Coverage*," to the Division of Health Care Finance and Policy for a review and evaluation on January 23, 2006. The bill would add "eating disorders" to the current list of nine biologically-based mental disorders for which insurers may not impose dollar and service limitations. The bill's lead sponsor is Representative Kay Khan. The Division interviewed insurers and providers in conducting its evaluation, and engaged Compass Health Incorporated to conduct an actuarial analysis.

The Division has determined that enactment of H. 3024 is not likely to result in an immediate or substantial increase in expenditures for the treatment of eating disorders. Under the current system, adult patients being treated for eating disorders seldom exhaust the current benefit levels mandated by statute. The Division believes that while the bill would ostensibly create unlimited mental health benefits for eating disorders, it may have minimal impact on the eating disorder treatment services authorized by Massachusetts insurers.

INTRODUCTION

The Mental Health Parity Law

The Massachusetts Mental Health Parity Act^{*} was enacted in 2000. Among other things, it requires insurance carriers, health maintenance organizations and Blue Cross Blue Shield plans to cover certain mental health services on a "non-discriminatory" basis such that a health plan may not impose any annual or lifetime dollar or unit of service limitations for treatment of such mental health services. The mental health services subject to the "non-discrimination" requirement include

- (1) nine "biologically based" mental disorders specified by statute;[†]
- (2) for children and adolescents under 19, non-biologically based conditions that substantially interfere with social interactions, psychopharmacological services and neuropsychological assessment services.

For other mental health diagnoses, health plans must provide medically necessary coverage up to 60 days of inpatient treatment, 24 outpatient visits, and must cover a range of inpatient, intermediate, and outpatient services that permits medically necessary care to take place in the least restrictive setting.

^{*} Chapter 80 of the Acts of 2000.

[†] The law designates nine mental disorders as biologically based. 1) schizophrenia, 2) schizoaffective disorder, 3) major depressive disorder, 4) bipolar disorder, 5) paranoia and other psychotic disorders, 6) obsessive-compulsive disorder, 7) panic disorder, 8) delirium and dementia, and 9) affective disorders.

Summary of the Legislation

As noted above, eating disorders are currently classified as a "non-biologically based" mental health disorder under the Mental Health Parity law. H 3024 would add eating disorders to the list of biologically based mental health disorders for which insurers may not impose any dollar or service limitations. Current law requires coverage of "non-biologically based" mental health disorders of at least 60 days per year of inpatient care and a minimum of twenty four mental health outpatient visits per year. If the bill were enacted, insurers could not limit treatment of adults for eating disorders to 60 days of inpatient treatment or 24 outpatient treatments per year.

BACKGROUND

Definition of Eating Disorders

Psychiatric diagnoses are categorized by the *Diagnostic and Statistical Manual of Mental Disorders*, often known as the DSM-IV. According to this manual, there are three diagnoses that comprise the "eating disorder" category: Anorexia Nervosa, Bulimia Nervosa and Eating Disorders Not Otherwise Specified including Binge Eating Disorders. The following are brief descriptions developed by the University of North Carolina (UNC) of the three diagnoses. The UNC analysis was funded by the federal Agency on Healthcare Research and Quality.

Anorexia nervosa (AN): a serious psychiatric illness marked by an inability to maintain a normal health body weight, often dropping well below 85% of ideal body weight. Patients who are still growing fail to make expected increases in weight (and often height) and bone density. Despite increasing weight loss, an individual with AN continue to obsess about weight, remain dissatisfied with the perceived size of the bodies, and engage an array of unhealthy behaviors to perpetuate weight loss (e.g. purging, dieting, excessive exercise, fasting).¹

Bulimia nervosa (BN): recurrent episodes of binge eating in combination with some form of inappropriate compensatory behavior. Binge eating is the consumption of an abnormally large amount of food coupled with a feeling of being out of control. Compensatory behaviors (aimed at preventing weight gain) include self-induced vomiting; the misuse of laxatives, diuretics, or other agents; fasting; and excessive exercise.²

Eating disorders not otherwise specified (EDNOS) include Binge Eating Disorder (BED) and five other disorders that do not meet criteria for AN or BN. BED is characterized by eating much larger amounts of food than most people would eat within a certain amount of time and a sense of lack of control over eating during episodes of overeating.³

Prevalence of Eating Disorders

The lifetime risk for Anorexia Nervosa among women is estimated at 0.3% to 1.0% and 0.1% for men.⁴ Bulimia Nervosa is estimated to be present in 1% of women and 0.1% of men⁵. Binge Eating Disorder has been estimated by several researchers to be present in 0.7% to 3% of

individuals.^{6,7,8,9} Eating disorders are commonly accompanied by other mental health diagnoses such as major depression and anxiety disorders.¹⁰

Medical Efficacy of Treatment

In April, 2006, the University of North Carolina at Chapel Hill Evidence-Based Practice Center published a technology assessment on the management of eating disorders. The study was funded by the US Department of Health and Human Services and concluded that the research on treatment efficacy and outcomes for Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder is not rigorous enough to establish how to best treat these conditions. The report notes that "(i)n the treatment literature, the largest deficiency rests with treatment efficacy for Anorexia Nervosa where the literature was weakest." In spite of the dearth of high quality research on effectiveness of various treatments, the provider community generally agrees on the course of treatment for eating disorder patients (see the next section, "Current Treatment Protocols for Eating Disorders").

Full recovery is estimated in 50 to 70% of adolescent patients¹¹ and 25 to 50% of adult patients¹² who have been hospitalized. Patients who do not recover suffer from long-term complications including weakened bones and excess bone fractures, low birth weight babies and death.¹³ Death occurs from suicide,¹⁴ medical complications associated with starvation, and purging related heart arrhythmias.¹⁵

Current Treatment Protocols and Treatment Issues

Although eating disorders are regarded as mental health diagnoses, treatment often requires both medical and behavioral care. Medical care is necessary for a patient whose body weight is so low that he or she requires a medical intervention to prevent and/or reverse physical harm from dangerously low weight. Behavioral treatments following the inpatient stay, however, are regarded as mental health treatment and are subject to the limits permitted by the statute. Eating disorders are often accompanied by at least one of nine "biologically-based" mental health diagnoses. As a result, treatment for people with an eating disorder who are also being treated for any of the nine biologically-based mental health diagnoses cannot be limited to the mental health minimum benefit of 60 inpatient days and 24 outpatient visits

Inpatient treatment for the medical effects of starvation is covered under the patient's medical, not mental health, benefit. Accordingly, there are no treatment limits for the medical conditions that result from eating disorders, including starvation and low body weight. Behavioral treatments address the behaviors that result in too little body mass, including restriction of calories, purging, use of diuretics, and excessive exercise. There are generally three criteria for determining whether a treatment is medical or behavioral. The three criteria, in order of importance, are:

- Where is the patient being treated – in an acute or psychiatric hospital? If in an acute hospital, on a medical-surgical or psychiatric unit?
- Who the primary treating clinician is – e.g. a psychiatrist or other physician?
- What is the primary diagnosis – a mental health or medical condition?

As noted above, health plans generally authorize the least intensive setting appropriate for a patient before authorizing a more intensive setting for treatment. As a result, an insurer may authorize day treatment, residential or inpatient care only if the patient does not respond to outpatient care. In authorizing care for eating disorder patients, insurers are less influenced by legal benefit limits than by the determination of the appropriate setting. In other words, a health plan is more likely to deny inpatient care for the behavioral treatment of a patient with an eating disorder on the basis that outpatient care is more appropriate than inpatient care, rather than because the inpatient benefit has been exhausted.

While healthcare providers generally agree that treatment should be provided in the least intensive setting that is appropriate, they are more likely to regard more intensive settings as more appropriate for a larger number of patients than insurance companies. In interviews, providers complained about the insurers' reluctance to authorize intensive treatment and the dearth of intensive treatment programs. In addition, providers cited the insurers' use of "percent of ideal body weight" as the sole or over-riding criteria to determine appropriateness of inpatient or residential care.^{16,17} Providers, on the other hand, tended to regard patients' ability or inability to regulate their food intake with the absence of supervision, as the criteria to determine the appropriate level of treatment. According to providers, residential programs may be appropriate for patients who are close to or even at their ideal body weight but still need constant supervision in order to maintain their weight. Providers contend that patients of residential programs should be transferred to day treatment programs only after they have demonstrated an ability to eat and keep down their food with less supervision. Patients are ready for outpatient care when they need less supervision than that provided in intensive day treatment programs.

As part of its review, the Division obtained data from the Office of Patient Protection concerning patient appeals of treatment denials. Patients may appeal to the Office of Patient Protection, within the Department of Public Health, for reasons of medical necessity when an insurer denies treatment benefits. This independent external review process is available to individuals who are covered by a fully insured Massachusetts health plan. Based on discussions with the Office, appeals brought by patients generally concern the level of care approved by insurers, rather than exhaustion of benefit limits. Eating disorder patients primarily appeal the insurers' denials of requests for residential treatment or inpatient care and approval is often given only for care in an outpatient setting. The Office of Patient Protection reports that nine patients, with eating disorders, filed appeals with the Office in 2006. Of the nine, five of the appeals were overturned. Additional appeals were filed in that year - although the patient's eating disorder was not the primary diagnosis.¹⁸

Experience of Other States

Thirty eight states, including Massachusetts, have enacted laws that create some level of parity between mental and physical illnesses. Data shows that these states experienced only small changes in utilization or costs for treating eating disorders.^{19,20,21} Ten states have legislation mandating health insurance coverage of people with eating disorders: California, Connecticut, Delaware, Maine, Maryland, Minnesota, North Dakota, Vermont, Washington and West Virginia.²² Although rules about the treatment of eating disorders vary by state, there is generally more variation of treatment options based upon the person's specific insurance policy rather than laws governing treatments.^{23,24} More than one respondent reported that two patients with the same diagnosis and care needs and who have the same insurance carrier may receive

authorizations for different care based upon differences in their health insurance policies. Although the U.S. Substance Abuse and Mental Health Services Administration conducted an analysis of the effects of Vermont's parity legislation, the analysis did not break down before and after costs for eating disorders. Mental health and substance abuse service costs increased (for Blue Cross and Blue Shield of VT) \$0.19 per member per month. The state of Maine estimated that creating full parity for eating disorders had a minimal affect on total mental health expenditures.²⁵

Minnesota passed a parity law in the 1990s that established equal treatment for mental and physical conditions regardless of the specific mental condition. Two Minnesota insurers estimated that costs did not rise or rise appreciably following passage of its full mental health parity law in the 1990s.^{26, 27} Insurers in Minnesota were not allowed to limit mental health inpatient days so it was not possible for a patient to exhaust the mental health inpatient benefit.^{28, 29} Despite the fact that unlimited benefits were covered, the report found that inpatient care tended to be refused on the basis that treatment should be provided in the "least restrictive setting."

Minnesota insurers did not routinely authorize inpatient care or residential treatment for eating disorder patients unless it was for the purpose of re-establishing a patient's body weight.^{30,31} Utilization of inpatient care and residential treatment for eating disorders did increase, however, following a lawsuit filed by the Minnesota Attorney General in 2000 against Blue Cross of Minnesota, following the death of an eating disorder patient whose request for inpatient care had been denied. Blue Cross of Minnesota settled with the Minnesota Attorney General in 2001. Blue Cross of Minnesota agreed to abide by the decision of an independent three person board established to review Blue Cross of Minnesota denials of provider treatment plans for certain mental health (including eating disorders) and substance abuse conditions. Since then, Blue Cross of Minnesota, and even other Minnesota insurers that were not bound to the Blue Cross of Minnesota agreement, have been less resistant to providers that seek authorization for residential care and intensive day treatment of eating disorder patients. Increased utilization of comprehensive behavioral treatments has been attributed to Blue Cross of Minnesota newly refocused criteria for ruling on providers' request for care. Since being formed, the three member board has not reviewed or overturned a substantial number of denials because providers generally receive authorization for the care they request.^{32,33,34} Data about how much costs have increased are not available at this time.

Fiscal Impact of Bill

M.G.L. c. 3, § 38C (d) requires the Division to assess eight different measures in estimating the fiscal impact of a mandated benefit:

- (1) the financial impact of mandating the benefit, including the extent to which the proposed insurance coverage would increase or decrease the cost of the treatment or the service over the next 5 years,
- (2) the extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next five years,
- (3) the extent to which the mandated treatment or services might serve as an alternative or more expensive or less expensive treatment or service,

- (4) the extent to which the insurance coverage may affect the number or types of providers of the mandated treatment or service over the next 5 years,
- (5) the effects of mandating the benefit on the cost of health care, particularly the premium, administrative expenses and indirect costs of large employers , small employers, employees and nongroup purchasers,
- (6) the effect of the proposed mandate on cost shifting between private and public payors of health care coverage,
- (7) the cost to health care consumers of not mandating the benefit in terms of out of pocket costs for treatment or delayed treatment; and
- (8) the effect on the overall cost of the health care delivery system in the commonwealth.

The statute also requires the Division to assess the medical efficacy of mandating the benefit, including the impact of the benefit to the quality of patient care and the health status of the population and the results of any research demonstrating the medical efficacy of the treatment or service compared to alternative treatments or services or not providing the treatment or services.

The Division engaged an actuarial firm, Compass Health Incorporated (Compass), to estimate the financial effect of passage of H. 3024. In its analysis, Compass compared the current cost for the treatment of children with eating disorders, which is not constrained by benefit limitation, to the cost of treating the population older than 18. This cost comparison assumes that the current treatment standard for children would become the standard for treating the over 18 population if eating disorders were defined as a "biologically based" mental health diagnosis not subject to benefit limitations.³⁵ Based on the current data showing that the medical necessity standard, rather than current benefit limits, determines the insurer's treatment for eating disorders, the actuary's fiscal impact estimate should be regarded as the maximum possible, but not the most probable, fiscal impact of the bill. It is not clear to what extent the assumption that insurers would change the current treatment standards for adults with eating disorders simply because of an elimination of benefit limitations would be borne out, especially since the mental health parity law not only imposes no benefit limitations for treatment of children with eating disorders, but also requires children's coverage for non-biologically based conditions that "substantially interfere" with social interactions.

FINANCIAL IMPACT OF MANDATE

DHCFP is required by M.G.L. c. 3, § 38C (d)(1) to evaluate the fiscal impact of proposed mandated benefits in nine specific areas:

1. The Division is required to assess the extent to which the proposed insurance coverage might increase or decrease the cost of a treatment or service over the next five years.

As noted above, the Division's actuary, Compass, estimated the maximum possible fiscal impact of the bill. The Compass analysis assumed that under the proposed mandate, the cost per-person treated per-year in the over 19 group would rise to the level of the cost per-person treated per-year in the under 19 group. Clinical experts indicated that treatment protocols are similar for each group.

Based on this assumption, Compass staff estimated costs over a five year time period. A summary of these estimates appears in Exhibit E1. The column on the far right reflects the mean annual premium change over 5 years and the total dollar impact on monthly premiums. Over the five years, the total cost is estimated to be \$60.4 million which is \$0.33 PMPM or approximately 0.09% of the total premium.

Exhibit E1 Summary of Cost Impact of Eating Disorders Mandate							
	2008	2009	2010	2011	2012	5-Year	
Total Impact (000)	\$ 9,380	\$ 9,859	\$ 10,364	\$ 10,894	\$ 51,948	\$ 60,405	
Total Monthly Premium Impact	\$ 0.30	\$ 0.32	\$ 0.33	\$ 0.35	\$ 0.37	\$ 0.33	
Percent of Premium	0.09%	0.09%	0.09%	0.09%	0.09%	0.09%	

Sample Results

An analysis of a sample of 2005 services provided to eating disorder patients with eating disorders appears in Exhibit II. The sample data provides information on 4,682 users of service of which 1,290 were under 19 years of age, and 3,392 were 19 and older. Consistent with the difference in benefits available to the under 19 and over 19 groups, the annual cost per user was \$2,965 for the under 19 group, and \$1,418 for those over 19. The difference in annual costs per user, \$1,548 was assumed to be due to the unlimited benefit available to those under 19.

Exhibit II Statistics on Costs for Eating Disorders Services Service Use and Payment from Sampled Health Plans 2005 Dates of Service						
Users	Average Enrollment	Users of Service	Payments	Cost per User	PMPM	
Total	1,958,130	4,682	\$ 8,633,465	\$ 1,844	\$ 0.37	
Under 19	469,951	1,290	\$ 3,825,012	\$ 2,965	\$ 0.68	
19 and Over	1,488,178	3,392	\$ 4,808,453	\$ 1,418	\$ 0.27	
Difference				\$ 1,548	\$ 0.41	

2. The Division is required to assess the extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next five years.

There is no data available that would permit the Division to quantify the extent to which the proposed coverage might affect the appropriate or inappropriate use of the treatment or service over the next five years. As noted above, if eating disorders were added to the list of biologically-based disorders, insurers would no longer be allowed to limit outpatient care to a minimum of 24 outpatient visits or inpatient care to 60 days. Providers who believe their patients would be better served in a more comprehensive and intensive care setting, might request their patients receive care in residential care facilities, acute care hospitals, or undergo intensive day treatment. In the absence of limits on the number of services provided, health care expenditures attributed to these patients could increase if their care is deemed medically appropriate and approved by insurers.

3. The Division is required to assess the extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatments or services.

There is no data available that would permit the Division to quantify the extent to which the mandated treatment might serve as an alternative for more expensive or less expensive treatments. As noted above, should additional treatment facilities become available, costs may in fact increase. However, one could expect that insurers may initially approve care in less expensive outpatient settings, if medically appropriate, prior to approving care in more acute and comprehensive settings.

4. The Division is required to assess the extent to which the insurance coverage might affect the number and types of providers of the mandated treatment or service over the next five years.

There is no data available that would permit the Division to quantify the extent to which the mandated treatment may result in establishment of additional inpatient or residential treatment facilities. Should H. 3024 become law, providers may determine that demand for additional residential treatment centers may increase and it is possible that additional treatment facilities could be established to provide this specialized care.

5. The Division is required to assess the effects of the mandated benefit on the cost of health care, particularly the premium, administrative expenses, and indirect costs of large and small employers, employees, and non-group purchasers.

Exhibit III provides information on the impact of the mandate on premiums including its effect on administrative expenses. If eating disorders were determined to be biologically based and the 19 and older population could have benefited by this mandate, it is estimated that an additional \$6.1 million would have been paid by insurers to fully-cover these individuals in 2005. (The \$1,548 difference in cost per user in the sample, multiplied by the 3,392 users aged 19 and older resulted in an estimate of \$5.2 million in increased medical costs in 2005. When administrative expenses are included, the total dollar impact increased to \$6.1 million.) When these costs are adjusted for inflation, these costs are projected to be \$10.9 million in 2008 which is \$0.30 PMPM or approximately 0.09% of the total premium.

Over the five years 2008-2012, the total cost is estimated at \$60.4 million. The per member per month cost for all eating disorders services was \$0.37 with the PMPM cost increasing by \$0.33 on average over the five years (see Exhibit E1). While the costs incurred by insured members as a result of mandating this benefit may seem to be negligible, opponents of mandated benefits are generally concerned with the increase in total costs (of all mandated benefits) to insured members.

Exhibit III Estimated Impact of Eating Disorders Mandate Service Use and Payment from Sampled Health Plans									
	2005 Sample	Full Population	2008	2009	2010	2011	2012	5 Year	
Per Patient Impact	\$ 1,548	\$ 1,548	1,791	1,881	1,975	2,074	2,178		
Monthly Premium Impact - Claims	\$ 0.22	\$ 0.22	\$ 0.26	\$ 0.27	\$ 0.29	\$ 0.30	\$ 0.31		
Administration Premium Impact	\$ 0.04	\$ 0.04	\$ 0.04	\$ 0.04	\$ 0.05	\$ 0.05	\$ 0.05		
Total Monthly Premium Impact	\$ 0.26	\$ 0.26	\$ 0.30	\$ 0.32	\$ 0.33	\$ 0.35	\$ 0.37		
Percent of Premium	0.09%	0.09%	0.09%	0.09%	0.09%	0.09%	0.09%		
Dollar Impact - Claims (000)	\$ 5,249	\$ 8,076	9,380	9,859	10,364	10,894	11,451	\$ 51,948	
Administration (000)	\$ 855	\$ 1,315	1,527	1,605	1,687	1,773	1,864	\$ 8,457	
Total Impact (000)	\$ 6,104	\$ 9,390	10,907	11,464	12,051	12,667	13,315	\$ 60,405	

Since the majority of large employers are self-insured, this mandate could disproportionately affect small employers. However, there are some large employers who voluntarily abide by state mandates and may choose to offer this expanded benefit.

6. The Division is required to assess the potential benefits and savings to large and small employers, employees, and non-group purchasers of the proposed mandate.

Some clinicians argue that early treatment, using a multidisciplinary approach, offers many patients the best opportunity to improve and many to recover. Insured employees who currently have paid for acute residential treatment out of pocket, for they or their family members, could possibly experience some savings should their insurer offer more intensive treatment options. However, premiums could rise to account for an increase in these services.

Some small employers could benefit by increased employee satisfaction if some of their employees or their family members avail themselves of additional treatment options offered by this mandate. This mandate would not affect the many large employers who are self-insured unless they choose to adopt this standard.

7. The Division is required to assess the effect of the proposed mandate on cost-shifting between private and public payers of health care coverage.

The proposed mandate only applies to commercial insurers, HMOs and BCBS and the Group Insurance Commission. It is not expected that this would result in any cost shifting between public and private payers.

8. The Division is required to assess the cost to health care consumers of not mandating the benefit in terms of out-of-pocket costs for treatment or delayed treatment.

In some instances, families report that they resort to using all their savings, including mortgaging their homes, in order to pay for residential care for their family member. Some clinicians argue that the provision of a comprehensive coordinated treatment plan early on in the patient's care contributes to chances for a successful long-term recovery. Should H. 3024 become law, patients may be afforded more comprehensive care in alternative settings. One might expect that insurers would still require providers first try less-intensive outpatient treatment options before authorizing more intensive therapy.

It is difficult to characterize the protocols used by all insurers to determine whether treatments will be available to patients as it often depends on a particular insurance product. Insurers offer many different products. Even within a particular product line offered by an insurer, an employer may opt for an option that covers acute residential while another employer may not choose to offer that option.

9. The Division is required to assess the effect of the proposed mandate on the overall cost of the health care delivery system in the Commonwealth.

Classifying eating disorders under the category of biologically-based illnesses could result in some increase in overall health care delivery system costs especially in the absence of an annual or lifetime dollar or unit of service limit. However, while the goal of this legislation maybe to offer more intensive care without service limits, the care may still not be offered based on the “least restrictive setting” provision applied by insurers.

ENDNOTES

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³ Ibid

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¹⁶ Ibid

¹⁷ Personal Communication in June, 2006 with Patricia Tarbox, Director of Eating Disorder Clinic, McLean Hospital, Belmont, MA.

¹⁸ Personal communication in March 2007 with Karen Granoff, Office of Patient Protection.

¹⁹ A Snapshot of the Implementation of California's Mental Health Parity Law, Mathematica Policy Research, Inc. March 2002,

²⁰ A Report to the Joint Standing Committee on Insurance and Financial Services of the 122nd Maine Legislature, Maine Bureau of Insurance, January, 2006

²¹ Personal Communication in July, 2006 with Judith Walker, General Counsel of Blue Cross of Minnesota.

²² National Eating Disorders Association Web-site: http://www.nationaleatingdisorders.org/p.asp?WebPage_ID=842

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- ²³ Personal Communication in June, 2006 with Patricia Tarbox, Director of Eating Disorder Clinic, McLean Hospital, Belmont, MA.
- ²¹ Personal Communication in July 2006 with Matt Eastwood, Director of Behavioral Health of Blue Cross of Minnesota
- ²⁵ Written communication in March, 2006 with Mary Hooper, Actuarial Assistant, Maine Bureau of Insurance.
- ²⁶ Personal Communication in July, 2006 with Matt Eastwood, Director of Behavioral Health of Blue Cross of Minnesota
- ²⁷ Personal Communication in August, 2006 Laurie Penning from Medica Health Plan, MN
- ²⁸ Personal communication in June, 2006 with Judith Walker, General Counsel of Blue Cross of Minnesota.
- ²⁹ Personal communication in June, 2006 with Matt Eastwood, Director of Behavioral Health of Blue Cross of Minnesota.
- ³⁰ Ibid.
- ³¹ Personal Communication in June, 2006 with Judith Walker, General Counsel of Blue Cross of Minnesota.
- ³² Ibid
- ³³ Personal Communication in July 2006 with Matt Eastwood, Director of Behavioral Health of Blue Cross of Minnesota.
- ³⁴ Personal Communication in June 2006 with Mike Vaneelow, Minnesota Attorney General's Office.
- ³⁵ Personal Communication in July, 2006 with Mark Santello, Associate Psychologist, McLean Hospital, Belmont, MA

APPENDICES

Appendix: I Actuarial Assessment – Compass Healthcare Inc.